

# Private Health Insurance Provisions of H.R. 3962

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## Summary

This report summarizes key provisions affecting private health insurance, including provisions to raise revenues, in Division A of H.R. 3962, the Affordable Health Care for America Act, as passed by the House of Representatives on November 7, 2009. H.R. 3962 is based on H.R. 3200, America's Affordable Health Choices Act of 2009, which was originally introduced on July 14, 2009, and was reported separately on October 14, 2009, by three House Committees—Education and Labor, Energy and Commerce, and Ways and Means.

Division A of H.R. 3962 focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, and providing financial assistance to certain individuals and, in some cases, small employers. In general, H.R. 3962 would require individuals to maintain health insurance and employers to either provide insurance or pay a payroll assessment, with some exceptions. Several insurance market reforms would be made, such as modified community rating and guaranteed issue and renewal. Both the individual and employer mandates would be linked to acceptable health insurance coverage, which would meet required minimum standards and incorporate the market reforms included in the bill. Acceptable coverage would include (1) coverage under a qualified health benefits plan (QHBP), which could be offered either through the newly created Health Insurance Exchange (the Exchange) or outside the Exchange through new employer plans; (2) grandfathered employment based plans; (3) grandfathered nongroup plans; and (4) other coverage, such as Medicare and Medicaid. The Exchange would offer private plans alongside a public option. Based on income, certain individuals could qualify for subsidies toward their premium costs and cost-sharing (deductibles and copayments); these subsidies would be available only through the Exchange. In the individual market (the nongroup market), a plan could be grandfathered indefinitely, but only if no changes were made to the terms and conditions of that plan, including benefits and cost-sharing, and premiums were only increased as allowed by statute. Most of these provisions would be effective beginning in 2013.

The Exchange would not be an insurer; it would provide eligible individuals and small businesses with access to insurers' plans in a comparable way. The Exchange would consist of a selection of private plans as well as a public option. Individuals wanting to purchase the public option or a private health insurance *not* through an employer or a grandfathered nongroup plan could *only* obtain such coverage through the Exchange. They would only be eligible to enroll in an Exchange plan if they were not enrolled in Medicare, Medicaid, and acceptable employer coverage as a full-time employee. The public option would be established by the Secretary of Health and Human Services (HHS), would offer three different cost-sharing options, and would vary premiums geographically. The Secretary would negotiate payment rates for medical providers, and items and services. The bill would also require that the Health Choices Commissioner to establish a Consumer Operated and Oriented Plan (CO-OP) program under which the Commissioner would make grants and loans for the establishment of not-for-profit, member-run health insurance cooperatives. These co-operatives would provide insurance through the Exchange.

Only within the Exchange, credits would be available to limit the amount of money certain individuals would pay for premiums and for cost-sharing (deductibles and copayments). (Although Medicaid is beyond the scope of this report, H.R. 3962 would extend Medicaid coverage for most individuals under 150% of poverty; individuals would be ineligible for Exchange coverage if they were eligible for Medicaid.)

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## Status of House Legislation

H.R. 3962, Affordable Health Care for America Act, was passed by the House of Representatives on November 7, 2009. H.R. 3962 is based on H.R. 3200, America's Affordable Health Choices Act of 2009, which was originally introduced on July 14, 2009, and was reported separately on October 14, 2009, by three House Committees—Education and Labor, Energy and Commerce, and Ways and Means.

On November 6, the Congressional Budget Office (CBO) released an estimate of the direct spending and revenue effects of H.R. 3962 that includes the manager's amendment proposed on November 3 and reflects the enactment of H.R. 3548, the Worker, Homeownership, and Business Assistance Act of 2009. CBO projects the bill would reduce federal deficits by \$109 billion over the 10-year period of 2010-2019 and, by 2019, would insure 96% of the non-elderly, legally present U.S. population. The gross 10-year cost of the Exchange subsidies (\$610 billion), increased federal Medicaid expenditures (\$425 billion), and tax credits for small employers (\$25 billion) would total \$1.052 trillion. Taking into account employer and individual tax penalties and other issues pertaining to coverage, the net cost of the coverage provisions, according to the CBO analysis, would be \$891 billion over 10 years. "Over the 2010–2019 period, the net cost of the coverage expansions would be more than offset by the combination of other spending changes, which CBO estimates would save \$427 billion, and receipts resulting from the income tax surcharge on high-income individuals and other provisions, which JCT [the Joint Committee on Taxation] and CBO estimate would increase federal revenues by \$574 billion over that period."<sup>1</sup>

## Overview of H.R. 3962

This report summarizes the key provisions affecting private health insurance in the Affordable Health Care for America Act, as passed by the House of Representatives on November 7, 2009. The bill focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, providing financial assistance to certain individuals, and, in some cases, small employers. The bill also includes provisions to raise revenues. In general, H.R. 3962 would include the following:

- Individuals would be required to maintain health insurance, and employers would be required to either provide insurance or pay a payroll assessment, with some exceptions.
- Several market reforms would be made, such as modified community rating and guaranteed issue and renewal.
- Both the individual and employer mandates would be linked to acceptable health insurance coverage, which would meet required minimum standards and incorporate the market reforms included in the bill. Acceptable coverage would include
  - coverage under a qualified health benefits plan (QHBP), which could be offered either through the newly created Exchange or outside the Exchange through new employer plans;
  - grandfathered employment based plans;
  - grandfathered nongroup plans; and

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<sup>1</sup> Congressional Budget Office, Letter to Rep. John D. Dingell, Analysis of the Affordable Health Care for America Act, [http://cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell\\_mgr\\_amendment\\_update.pdf](http://cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf).

- other coverage, such as Medicare and Medicaid.
- The Exchange would be established under a new independent federal agency (the Health Choices Administration), headed by a Commissioner. The Exchange would offer private plans alongside a public option.
- Certain individuals with incomes below 400% of the federal poverty level could qualify for subsidies toward their premium costs and cost-sharing; these subsidies would be available only through the Exchange.
- In the individual market (the nongroup market), a plan could be grandfathered indefinitely, but only if no changes were made to the terms and conditions of the plan, including benefits and cost-sharing, and premiums were only increased as allowed by statute.
- The bill would also establish a Consumer Operated and Oriented Plan (CO-OP) program under which grants and loans would be provided to encourage the creation of not-for-profit, member-run health insurance cooperatives that would operate in the Exchange.
- This bill would not affect plans covering specific services, such as dental or vision care.
- Most of these provisions would be effective beginning in 2013.
- Revenues would be raised by limiting employer deductions for certain health insurance plans and modifying tax-advantaged accounts currently used for health care spending and coverage, among other provisions.

## Overview of Report

This report begins by providing background information on key aspects of the private insurance market as it exists currently. This information is useful in setting the stage for understanding how and where H.R. 3962 would reform health insurance. The report summarizes key provisions affecting private health insurance in Division A of H.R. 3962,<sup>2</sup> passed by the House of Representatives on November 7, 2009. Although most of the provisions would be effective beginning in 2013, the table in the **Appendix** shows the timeline for implementing provisions effective prior to 2013.

Although the description that follows segments the private health insurance provisions into various categories, these provisions are interrelated and interdependent. For example, H.R. 3962 includes a number of provisions to alter how current private health insurance markets function, primarily for individuals who purchase coverage directly from an insurer or through a small employer. H.R. 3962 would require that insurers not exclude potential enrollees or charge them premiums based on pre-existing health conditions. In a system where individuals voluntarily choose whether to obtain health insurance, however, individuals may choose to enroll only when they become sick, known as “adverse selection,” which can lead to higher premiums and greater uninsurance. When permitted, insurers often guard against adverse selection by adopting policies

<sup>2</sup> This report does not address other sections of H.R. 3962, which are discussed in the following CRS Reports: CRS Report R40898, *Medicare Program Changes in H.R. 3962, Affordable Health Care for America Act*, coordinated by Patricia A. Davis; CRS Report R40900, *Medicaid and Children’s Health Insurance Program (CHIP) Provisions in Affordable Health Care for America Act (H.R. 3962)*, coordinated by Elicia J. Herz; CRS Report R40902, *Indian Health Care Provisions in H.R. 3962*, by Roger Walke and Elayne J. Heisler; and CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead.

such as excluding preexisting conditions. If reform eliminates many of the tools insurers use to guard against adverse selection then, instead, America's Health Insurance Plans (AHIP), the association that represents health insurers, has stated that individuals must be required to purchase coverage, so that not just the sick enroll.<sup>3</sup>

Furthermore, some individuals currently forgo health insurance because they cannot afford the premiums. If individuals are required to obtain health insurance, one could argue that adequate premium subsidies must be provided by the government and/or employers to make practical the individual mandate to obtain health insurance, which is in turn arguably necessary to make the market reforms possible. In addition, premium subsidies without cost-sharing subsidies may provide individuals with health insurance that they cannot afford to use. So, while the descriptions below discuss various provisions separately, the removal of one from the bill could be deleterious to the implementation of the others.

The private health insurance provisions are presented under the following topics within Division A of H.R. 3962:

- Individual and employer mandates: the requirement on individuals to maintain health insurance and on employers to either provide health insurance or pay into the Exchange, with penalties and taxes for noncompliance.
- Private health insurance market reforms.
  - Immediate Reforms.
- Health Insurance Exchange, through which the following can only be offered:
  - Public health insurance option.
  - Premium and cost-sharing subsidies.
  - CO-OP Program.
- Selected revenue provisions related to health insurance.
- Other Provisions
  - Abortion.
  - Medical malpractice.
  - End-of-life care.

## Background

Americans obtain health insurance in different settings and through a variety of methods. People may get health coverage in the private sector or through a publicly funded program, such as Medicare or Medicaid. In 2008, 60% of the U.S. population had employment-based health insurance. Employers choosing to offer health coverage may either purchase insurance or choose to self-fund health benefits for their employees. Other individuals obtained coverage on their own

<sup>3</sup> AHIP, "Health Plans Propose Guaranteed Coverage for Pre-Existing Conditions and Individual Coverage Mandate," November 19, 2008, available at <http://www.ahip.org/content/pressrelease.aspx?docid=25068>. See also Blue Cross Blue Shield Association, "BCBSA Announces Support for Individual Mandate Coupled with a Requirement for Insurers to Offer Coverage to All," November 19, 2008, at <http://www.bcbs.com/news/bcbsa/bcbsa-announces-support-for.html>.

in the nongroup market. However, there is no federal law that either requires individuals to have health insurance or requires employers to offer health insurance. Approximately 46 million Americans were estimated to be uninsured in 2008.<sup>4</sup>

Individuals and employers choosing to purchase health insurance in the private market fit into one of the three segments of the market, depending on their situation—the large group (large employer) market, the small group market, and the nongroup market.<sup>5</sup>

More than 95% of large employers offer coverage.<sup>6</sup> Large employers are generally able to obtain lower premiums for a given health insurance package than small employers and individuals seeking nongroup coverage. This is partly because larger employers enjoy economies of scale and a larger “risk pool” of enrollees, which makes the expected costs of care more predictable. Employers generally offer large subsidies toward health insurance, thus making it more attractive for both the healthier and the sicker workers to enter the pool. So, not only is the risk pool larger in size, but it is more diverse. States have experimented with ways to create a single site where individuals and small employers could compare different insurance plans, obtain coverage, and sometimes pool risk. Although most of these past experiments failed (e.g., California’s PacAdvantage<sup>7</sup>), other states have learned from these experiences and have fashioned potentially more sustainable models (e.g., Massachusetts’ Connector<sup>8</sup>). There are private-sector companies that also serve the role of making various health insurance plans easier to compare for individuals and small groups (e.g., eHealthInsurance), available in most, but not all, states because of variation in states’ regulations.

Less than half of all small employers (less than 50 employees) offer health insurance coverage;<sup>9</sup> such employers cite cost as the primary reason for not offering health benefits. One of the main reasons is a small group’s limited ability to spread risk across a small pool. Insurers generally consider small firms to be less stable than larger pools, as one or two employees moving in or out of the pool (or developing an illness) would have a greater impact on the risk pool than they would in large firms. Other factors that affect a small employer’s ability to provide health insurance include certain disadvantages small firms have in comparison with their larger counterparts: small groups are more likely to be medically underwritten, have relatively little market power to negotiate benefits and rates with insurance carriers, and generally lack

<sup>4</sup> CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured in 2008*.

<sup>5</sup> Health insurance can be provided to groups of people that are drawn together by an employer or other organization, such as a trade union. Small groups typically refer to firms with between 2 and 50 workers, although some self-employed individuals are considered “groups of one” for health insurance purposes in some states. Consumers who are not associated with a group can obtain health coverage by purchasing it directly in the nongroup (or individual) market.

<sup>6</sup> Where the firm has 50 or more workers, 96.5% of private-sector employers offered health insurance in 2008. Where the firm has fewer than 50 workers, 43.2% of private-sector employers offered health insurance in 2008. “Table II.A.2(2008) Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2008,” Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2008 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), [http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2008/tia2.pdf](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tia2.pdf).

<sup>7</sup> PacAdvantage was created as part of the small business health insurance reforms enacted in California in 1992, as a state-established health insurance pool to help cover small-business employees in California. PacAdvantage was created to allow small businesses to band together and negotiate lower insurance premiums for their employees, but it did little to make insurance more affordable. Over time, employers whose workers had the lowest health risks exited the pool for plans with cheaper premiums, leaving the program with the highest-risk members and driving up costs. See, for example, Rick Curtis and Ed Neuschler, “What Health Insurance Exchanges or Choice Pools Can and Can’t Do About Risks and Costs,” Institute for Health Policy Solutions, p. 1.

<sup>8</sup> See <http://www.mahealthconnector.org>.

<sup>9</sup> See footnote 6.



economies of scale. Allowing these firms to purchase insurance through a larger pool, such as an Association, Gateway or an Exchange, could lower premiums for those with high-cost employees.

Depending on the applicable state laws, individuals who purchase health insurance in the nongroup market may be rejected or face premiums based on their health status, which can make premiums lower for the healthy but higher for the sick. Even when these individuals obtain coverage, there may be exclusions for certain conditions. Reforms affecting premiums ratings would likely increase premiums for some, while lowering premiums for others, depending on their age, health, behaviors, and other factors.

States are the primary regulators of the private health insurance market, though some federal regulation applies, mostly affecting employer-sponsored health insurance (ESI).<sup>10</sup> The Health Insurance Portability and Accountability Act (HIPAA) requires that coverage sold to small groups (2-50 employees) must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. All states require issuers to offer policies to firms with 2-50 workers on a guaranteed issue basis, in compliance with HIPAA. As of January 2009 in the small group market, 13 states also require issuers to offer policies on a guaranteed issue basis to the self-employed “groups of one.” And as of December 2008 in the individual market, 15 states require issuers to offer some or all of their insurance products on a guaranteed issue basis to non-HIPAA eligible individuals.

Most states currently impose premium rating rules on insurance carriers in the small group and individual markets. The spectrum of existing state rating limitations ranges from pure community rating to adjusted (or modified) community rating, to rate bands, to no restrictions. Under pure community rating, all enrollees in a plan pay the same premium, regardless of their health, age, or any other factor. Only two states (New Jersey and New York) use pure community rating in their nongroup markets, and only New York imposes pure community rating rules in the small group market. Adjusted community rating prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key factors such as age or gender. Rate bands allow premium variation based on health, but such variation is limited according to a range specified by the state. Rate bands are typically expressed as a percentage above and below the index rate (i.e., the rate that would be charged to a standard population if the plan is prohibited from rating based on health factors).<sup>11</sup>

Federal law requires that group health plans and health insurance issuers offering group health coverage must limit the period of time when coverage for preexisting health conditions may be excluded.<sup>12</sup> As of January 2009, in the small group market, 21 states had preexisting condition

<sup>10</sup> Federal law mandates compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, procedures for appealing denied benefit claims, rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

<sup>11</sup> If a state establishes a rate band of +/- 25%, then insurance carriers can vary premiums, based on health factors, up to 25% above and 25% below the index rate.

<sup>12</sup> Under HIPAA, a plan is allowed to look back only six months for a condition that was present before the start of coverage in a group health plan. Specifically, the law says that a preexisting condition exclusion can be imposed on a condition only if medical advice, diagnosis, care, or treatment was recommended or received during the six months prior to the enrollment date in the plan. If an individual has a preexisting condition that can be excluded from plan coverage, then there is a limit to the preexisting condition exclusion period that can be applied. HIPAA limits the preexisting condition exclusion period for most people to 12 months (18 months for late enrollment). In addition, some people with a history of prior health coverage will be able to reduce the exclusion period even further using “creditable coverage” (prior group coverage that meets the statutory requirements).

exclusion rules that provided consumer protection above the federal standard.<sup>13</sup> And as of December 2008, in the individual market, 42 states limit the period of time when coverage for preexisting health conditions may be excluded for certain enrollees in that market.<sup>14</sup> In fact, while there are a handful of federal benefit mandates for health insurance that apply to group coverage, there are more than 2,000 benefit mandates imposed by the states.<sup>15</sup>

One issue receiving congressional attention is whether a publicly sponsored health insurance plan should be offered as part of the insurance market reform. Some proponents of a public option see it as potentially less expensive than private alternatives, as it would not need to generate profits or pay brokers to enroll individuals and might have lower administrative costs. Some proponents argue that offering a public plan could provide additional choice and may increase competition, since the public plan might require lower provider payments and thus charge lower premiums. Some opponents question whether these advantages would make the plan a fair competitor, or rather provide the government with an unfair advantage in setting prices, in authorizing legislation, or in future amendments. Ultimately, they fear that these advantages might drive private plans from the market.<sup>16</sup>

The relative performance of health insurance organization by profit status has received some attention. Health insurance is provided by organizations that are either for-profit or non-profit in terms of their tax status. Some studies have suggested that non-profits perform better in key areas such as quality. For example, a study published in the *Journal of the American Medical Association (JAMA)* in 1999 found that non-profit health maintenance organizations (HMOs) scored higher on all 14 Healthplan Employer Data and Information Set (HEDIS)<sup>17</sup> quality measures studied.<sup>18</sup> These results were generally replicated in a study published in 2006 of 272 health plans conducted by researchers at the University of California at Berkeley and the National Committee for Quality Assurance (NCQA).<sup>19</sup> Health insurance co-operatives, a subset of non-

<sup>13</sup> See “Small Group Health Insurance Market Pre-Existing Condition Exclusion Rules, 2009,” at <http://www.statehealthfacts.org/comparetable.jsp?ind=352&cat=7>.

<sup>14</sup> See “Individual Market Portability Rules, 2008,” at <http://www.statehealthfacts.org/comparetable.jsp?ind=355&cat=7>.

<sup>15</sup> Federal law requires, for example, that group health plans and insurers that cover maternity care also cover minimum hospital stays for the maternity care and offer reconstructive breast surgery if the plan covers mastectomies. States have adopted mandates, for example requiring coverage of certain benefits, such as mammograms, well-child care, and drug and alcohol abuse treatment. For additional information about state benefit mandates, see “Health Insurance Mandates in the States, 2009,” at [http://www.cahi.org/cahi\\_contents/resources/pdf/HealthInsuranceMandates2009.pdf](http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf).

<sup>16</sup> Currently, Medicare is an example of a federal public health insurance program for the aged and disabled. Under Medicare, Congress and the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) determine many parameters of the program. These include eligibility rules, financing (including determination of payroll taxes and premiums), required benefits, payments to health care providers, and cost-sharing amounts. However, even within this public plan, CMS subcontracts with private companies to carry out much of the administration of the program.

<sup>17</sup> HEDIS is a registered trademark of the National Committee for Quality Assurance and is a tool used by more than 90% of health plans to measure performance. In total, HEDIS consists of 71 measures across 8 domains of care.

<sup>18</sup> Himmelstein, Wollhandler, Hellander & Wolf (1999). Quality of care in investor-owned vs. not-for-profit HMOs. *JAMA*, 281(2), 159-163.

<sup>19</sup> Gillies et al (2006). The Impact of Health Plan Delivery System Organization on Clinical Quality and Patient Satisfaction. *Health Services Research*, 14(4), 1181-1199.

profit plans, have performed particularly well as detailed in recent case studies of Group Health Cooperative of Seattle (GHC)<sup>20</sup> and HealthPartners of Minnesota.<sup>21</sup>

As of 2008, 47% of the enrollment in private health plans was in non-profit health insurance organizations.<sup>22</sup> However, there are relatively few health insurance co-operative organizations in the United States. Some congressional attention has been focused on options to incentivize the creation of new health insurance co-operatives. Advocates of this position argue that co-operatives invest retained earnings back into the plan or to enrollees in the form of lower premiums, lower cost-sharing, expanded benefits, and innovations such as wellness programs, chronic disease management, and integrated care. Opponents of the proposal assert that co-operatives have not been successful in most of the country and that evidence is lacking that co-operatives would make health insurance more affordable.

## Reforms Prior to Full Implementation on January 1, 2013

Several provisions of the bill would take effect prior to the full implementation on January 1, 2013. Many of these requirements would be administrative in nature and are necessary steps leading up to full implementation. These provisions are not discussed here. See the **Appendix** for these items. However, some of the provisions that would take effect prior to January 1, 2013, are more substantive and include the following:

- Postretirement reductions in retiree health benefits would be prohibited.
- Individuals would be allowed to keep their COBRA coverage until the Exchange is up and running.
- The Secretary would establish a temporary national high-risk pool program to provide health benefits to eligible individuals during the period beginning on January 1, 2010, and ending when the Health Insurance Exchange is established.
- Each health insurance issuer that offers health insurance coverage in the small or large group market would provide a rebate if the coverage has a medical loss ratio below a level specified by the Secretary (but not less than 85%). The provision sunsets once plans are offered via the Exchange. This provision would also apply to the individual market unless the Secretary determines that the application of this policy may destabilize the existing individual market.
- Health insurance issuers would have to submit a justification to the Secretary and the states for any premium increases prior to implementation of the increase.
- The bill would allow individuals through age 26 who were not otherwise covered to remain on their parents' group or individual plans, at their parents' discretion.

<sup>20</sup> D. McCarthy, K. Mueller, and I. Tillmann, *Group Health Cooperative: Reinventing Primary Care by Connecting Patients with a Medical Home*, The Commonwealth Fund, July 2009.

<sup>21</sup> D. McCarthy, K. Mueller, and I. Tillmann *HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda*, The Commonwealth Fund, June 2009.

<sup>22</sup> Atlantic Information Services (AIS) *Health Plans facts, trends and data: 2008-2009 13<sup>th</sup> edition*.

- In both the group and individual markets (prior to the complete prohibition in 2013), the bill would reduce the window that plans can look back for pre-existing conditions from 6 months to 30 days and shorten the period that plans may exclude coverage of certain benefits. The bill would prohibit acts of domestic violence from being treated as a pre-existing condition.
- For both the group and individual markets, plans would have to cover benefits for a dependent child's congenital or developmental deformity or disorder.
- For both the group and individual markets, the bill would prohibit aggregate dollar lifetime limits on benefits.
- The Secretary would issue guidance implementing the prohibition on rescission in the group and individual markets. This guidance would limit the situations in which an insurer may rescind, or cancel, a person's health insurance policy.
- The Secretary would establish a temporary reinsurance program to assist participating employment-based plans with the cost of providing health benefits to retirees and to eligible spouses, surviving spouses and dependents of such retirees.

## Individual and Employer Mandates

### Individual Mandate

H.R. 3962 includes a mandate for most individuals to have health insurance, with penalties for noncompliance. Individuals would be required to maintain acceptable coverage, defined as coverage under a qualified health benefits plan (QHBP), an employment-based plan, a grandfathered nongroup plan, part A of Medicare, Medicaid, military coverage (including Tricare), veteran's health care program, services for members of Indian tribes (through the Indian Health Service, a tribal organization or an urban Indian organization), and coverage as determined by the Secretary in coordination with the Commissioner. Individuals who did not maintain acceptable health insurance coverage for themselves and their children could be required to pay an additional tax, prorated for the time the individual (or family) does not have coverage, equal to the lesser of (1) 2.5% of the taxpayer's modified adjusted gross income<sup>23</sup> (MAGI) over the amount of income required to file a tax return, or (2) the national average premium for applicable single or family coverage.<sup>24</sup>

Some individuals would be provided with subsidies to help pay for the costs of their premiums and cost-sharing. (A complete description of who is eligible and the amount of subsidies is found in the section on premium and cost-sharing credits). Others would be exempt from the individual mandate, including nonresident aliens, individuals residing outside of the United States, individuals residing in possessions of the United States, those with qualified religious exemptions, those allowed to be a dependent for tax-filing purposes, and others granted an exemption by the Secretary.

<sup>23</sup> For this purpose, MAGI is defined as adjusted gross income (AGI) without the exclusions for U.S. citizens or residents living abroad, plus tax-exempt interest.

<sup>24</sup> For this purpose, national average premium is defined as the average premium determined by the Secretary under a basic plan offered in a Exchange for that calendar year.

## Employer Mandate: Health Coverage Participation Requirements

H.R. 3962 would require employers either to offer individual and family coverage under a QHBP (or current employment-based plan) to their employees or to pay a set amount into the Exchange, with some exceptions. Employers would include private-sector employers, churches, and federal, state, local and tribal governments.

For those employers that chose to offer health insurance, the following rules would apply:

- Employers could offer employment-based coverage<sup>25</sup> or, for certain small businesses, they could offer coverage through an Exchange plan (see section on rules for employer eligibility for Exchange plans).
- Current employment-based health plans would be grandfathered for five years, at which time any plan offered by an employer would have to meet (and could exceed) the requirements of the essential benefits package.
- Employers would have to contribute at least 72.5% of the lowest-cost QHBP or current employment-based plan they offered<sup>26</sup> (65% for those electing family coverage)<sup>27</sup>—prorated for part-time employees.
- Salary reductions used to offset required employer contributions would not count as amounts paid by the employer.
- Employers would automatically enroll their employees into the plan for individual coverage with the lowest associated employee premium, unless the employee selected a different plan or opted out of employer coverage. Employers would be required to provide written notice detailing the employee's rights and obligations relating to auto enrollment.
- Employers would be required to provide certain information to show compliance with health participation requirements, including (1) certification as to whether the employer offered its full-time employees (and dependents) enrollment in a QHBP or current employment-based plan; (2) monthly premiums for the lowest cost plan; (3) name, address, and other information of each full-time employee enrolled in a plan; and (4) other information as required.
- The Secretary of HHS, in coordination with the Commissioner, could terminate an employer's election to provide health insurance if the employer was in substantial noncompliance with the health coverage participation requirements.

<sup>25</sup> In general, employers that elected to provide coverage but failed to actually meet the health coverage participation requirements would be subject to a tax of \$100 per day for each employee to whom the failure applied. This tax would not apply for failures corrected within 30 days, in cases where the employer could not have reasonably been aware of the failure, and other exceptions. For failures due to a reasonable cause and not willful neglect, the tax would be limited to the lesser of 10% of the amount paid or incurred for the employment-based health plan for the prior year or \$500,000.

<sup>26</sup> For employers offering coverage through Exchange plans, their minimum contribution would be based on the reference premium amounts (as defined in the Exchange) for the premium rating area in which the individual or family resides.

<sup>27</sup> In 2008, employers that offered health insurance on average paid 80% of the premium for single coverage and 72% for family coverage. Tables II.C.3 and II.D.3, 2008 MEPS-IC, [http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2008/tiic3.pdf](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiic3.pdf) and [http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2008/tiid3.pdf](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiid3.pdf).

As shown in **Table 1**, employers with aggregate wages over \$750,000 that chose not to offer coverage would be subject to an excise tax equal to 8% of the average wages paid by the employer. The table shows the required level of payroll assessments for smaller employers.

**Table 1. Annual Contribution Requirements  
In Lieu of Offering Health Insurance**

Required Employer Contribution	Aggregate Payroll for Preceding Calendar Year
0%	Does not exceed \$500,000
2%	Exceeds \$500,000 but does not exceed \$585,000
4%	Exceeds \$585,000 but does not exceed \$670,000
6%	Exceeds \$670,000 but does not exceed \$750,000
8%	Exceeds \$750,000

Even if an employer offered employment-based coverage, employees could decline or disenroll from this insurance and instead enroll in a plan through the Exchange (although such individual may be responsible for all of the premium). Beginning in 2014, with respect to an employee who declines the employers qualifying coverage, employers with aggregate wages above \$750,000 would be assessed 8% of average wages,<sup>28</sup> with similar adjustments for small employers, as those described above. (This payroll assessment would not be required for an employee who was not the primary insured individual but was covered as a spouse or dependent in an Exchange plan.) The employer's payroll assessment for this group of individuals would go into the Exchange but would *not* apply toward the individual's premium. In addition, as discussed below, full-time employees who are offered their employer's qualifying coverage would generally not be eligible for any premium or cost-sharing credits (absent the limited instances<sup>29</sup>). Thus, in general, a full-time employee who opted for Exchange coverage rather than the employer's qualifying coverage would be responsible for 100% of the premium in the Exchange.

### Small Business Credit

Certain small businesses would be eligible for a 50% credit toward their share of the cost of qualified employee health coverage for no more than two taxable years. This credit would be phased out as average employee compensation increased from \$20,000 to \$40,000 and as the number of employees increased from 10 to 25. Employees would be counted if they received at least \$5,000 in compensation, but the credit would not apply toward insurance for employees whose compensation exceeded \$80,000 (highly compensated employees). Adjustments for inflation would be applied to the average employee compensation and to the limit on highly compensated employees, beginning after tax year 2013. This credit would be treated as part of the general business credit and would not be refundable; it would be available only to a business with

<sup>28</sup> This payroll assessment would be limited, so that it could be no more than the contribution that the employer would have been required to make had the employee elected to enroll in a plan offered by the employer.

<sup>29</sup> Beginning in 2014, full-time employees whose premium costs under a group health plan exceed 12% of current modified adjusted gross income could obtain premium credits.



a tax liability. A non-profit organization, for example, would be ineligible for the small business credit.

## **Private Health Insurance Market Reforms**

### **Qualified Health Benefits Plans (QHBP)**

H.R. 3962 would establish new federal health insurance standards applicable to new, generally available health plans specified in the bill—qualified health benefits plans (QHBP). Some of these reforms would continue the application of the immediate reforms. Among the market reforms applicable to QHBPs (including the public health insurance option) are provisions that would do the following:

- Prohibit coverage exclusions of pre-existing health conditions, or limitations on coverage based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or source of injury (including conditions arising out of acts of domestic violence) or similar factors. (A “pre-existing health condition” is a medical condition that was present before the date of enrollment for health coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.)
- Require coverage to be offered on both a guaranteed issue and guaranteed renewal basis. (“Guaranteed issue” in health insurance is the requirement that an issuer accept every applicant for health coverage. “Guaranteed renewal” in health insurance is the requirement on an issuer to renew group coverage at the option of the plan sponsor [e.g., employer] or nongroup coverage at the option of the enrollee. Guaranteed issue and renewal alone would not guarantee that the insurance offered was affordable; this would be addressed in the rating rules.) (This provision not only applies to QHBPs but also to all individual and group health plans whether offered in or out of the Exchange.)
- Require premiums to be determined using adjusted community rating rules. (“Adjusted, or modified, community rating” prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key characteristics such as age or gender.) Under H.R. 3962, premiums would be allowed to vary based only on age (by no more than a 2:1 ratio based on age categories specified by the Commissioner), premium rating area (as permitted by states or the Commissioner), and family enrollment (so long as the ratio of family premium to individual premium is uniform, as specified under state law and consistent with Commissioner rules).
- Impose new non-discrimination standards building on existing non-discrimination rules, and adequacy standards for insurers’ networks of providers, such as doctors, and apply existing mental health parity rules.
- Require coverage to provide to the policyholder the option of keeping qualified dependent children on the family’s policy, so long as the child is under 27 years of age and is not enrolled in any other health plan.
- Require notification to plan enrollees of any decrease in coverage or increase in cost-sharing at least 90 days prior to the effective date of such changes.

H.R. 3962 would also require QHBPs to cover certain broad categories of benefits, prohibit cost-sharing on preventive services, limit annual out-of-pocket spending, prohibit annual and lifetime benefit limits on covered health care items and services, comply with network adequacy standards, meet the standards for the “essential benefits package,” and be equivalent in its scope of benefits to the average employer health plan.

New individual policies issued in 2013 or after could be offered only as an Exchange plan. Existing group plans would have to transition to QHBP standards by 2018. Existing nongroup insurance policies would be grandfathered as long as there are no changes to the terms or conditions of the coverage (except as required by law), including benefits and cost-sharing. Such policies would be required to meet other conditions, including increasing premiums only according to statute.

## **Health Care Choice Compacts**

H.R. 3962 would allow states to form Health Care Choice Compacts for the purpose of facilitating the sale and purchase of individual health insurance plans across state lines. The Secretary would request the National Association of Insurance Commissioners (NAIC) to develop model guidelines for the creation of such compacts, which would subject coverage sold in multiple states under the compact to the laws and regulations of one primary state, but preserve the authority of each secondary state to enforce specific rules (e.g., consumer protection standards). The Secretary would make grants available to states for activities related to regulating health insurance coverage sold in secondary states.

## **Essential Benefits Package**

QHBPs would be required to cover at least the “essential benefits package” but could offer additional benefits. The essential benefits package would cover specified items and services, prohibit cost-sharing on preventive services, limit annual out-of-pocket spending, prohibit annual and lifetime benefit limits on covered health care items and services, comply with network adequacy standards, and be equivalent in its scope of benefits to the average employer health plan in 2013 (as certified by the Office of the Actuary of the Centers for Medicare and Medicaid Services).

The essential benefits package would be required to cover the following items and services:

- hospitalization;
- outpatient hospital and clinic services, including emergency department services;
- services of physicians and other health professionals;
- services, equipment, and supplies incident to the services of a physician or health professional in clinically appropriate settings;
- prescription drugs;
- rehabilitative and “habilitative” services (i.e., services to maintain the physical, intellectual, emotional, and social functioning of developmentally delayed individuals);
- mental health and substance use disorder services;
- certain preventive services (no cost-sharing permitted) and vaccines;
- maternity care;



- well baby and well child care *and* oral health, vision, and hearing services, equipment, and supplies for those under age 21; and
- durable medical equipment, prosthetics, orthotics, and related supplies.

The annual out-of-pocket limit in 2013 would be no more than \$5,000 for an individual and \$10,000 for a family, adjusted annually for inflation. To the extent possible, the Secretary would establish cost-sharing levels using copayments (a flat dollar fee) and not coinsurance (a percentage fee).

Cost-sharing under the essential benefits package would be specified by the Health Benefits Advisory Committee and the HHS Secretary (see discussion in the next section) so that the essential benefits package would cover an average of 70% of covered health care claims.<sup>30</sup> As discussed in greater detail below, plans offered through the Exchange could have less cost-sharing or richer benefit packages than the essential benefits package (Basic plan), but only as Enhanced, Premium, and/or Premium-Plus plans. Employer plans (excluding grandfathered plans or those obtained through the Exchange) would have the flexibility to offer plans with employee cost-sharing that was less than (but not more than) the levels specified by the Secretary for the essential benefits package.

## Health Benefits Advisory Committee

The Health Benefits Advisory Committee (HBAC) would be established to make recommendations to the Secretary regarding the essential benefits package and for coverage offered through the Health Insurance Exchange, including covered benefits, specific cost-sharing levels, and updates to the essential benefits package. The Committee would develop cost-sharing structures to be consistent with actuarial values specified for different cost-sharing plan tiers (i.e., essential/Basic, Enhanced, and Premium plans) offered in the Exchange. In developing its recommendations, the Committee would incorporate innovation in health care, consider how the benefits package would reduce health disparities, and allow for public input as part of developing its recommendations.

Within 45 days of receiving HBAC's recommendations, the Secretary would be required either to adopt the benefit standards as written or not adopt the benefit standards, notify HBAC of the reasons for this decision, and provide an opportunity for HBAC to revise and resubmit its recommendations. The Secretary would be required to adopt an initial set of benefit standards within 18 months of enactment either by adopting the HBAC recommendations (and any revisions) or, absent that, by proposing an initial set of benefit standards.

## Health Insurance Exchange

### Exchange Structure

In addition to federalizing private health insurance standards, H.R. 3962 would also create a "Health Insurance Exchange," similar in many respects to existing entities like the Massachusetts Connector and eHealthInsurance, to facilitate the purchase of QHBPs by certain individuals and small businesses. The Exchange would not be an insurer; it would provide eligible individuals and small businesses with access to insurers' plans in a comparable way (in the same way, for

<sup>30</sup> Sec. 222(c)(3) states, "The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under ... the essential benefits package if there were no cost-sharing imposed."

example, that Travelocity or Expedia are not airlines but provide access to available flights and fares in a comparable way). The Exchange would have additional responsibilities as well, such as negotiating with plans, overseeing and enforcing requirements on plans (in coordination with state insurance regulators), and determining eligibility for and administering premium and cost-sharing credits.

Under H.R. 3962, the Exchange would be established under a new independent federal agency (the Health Choices Administration), headed by a Commissioner. The federal Exchange's startup and operating costs, along with payments for premium and cost-sharing credits discussed below, would be paid for out of a new Health Insurance Exchange Trust Fund, funded by (1) taxes on certain individuals who did not obtain acceptable coverage, (2) penalties for employers whose coverage failed to meet the requirements for coverage, (3) payroll assessments by employers who opted not to provide insurance coverage, (4) payroll assessments by employers (beginning in 2014) whose employees opt for Exchange coverage instead of employment-based coverage,<sup>31</sup> and (5) such additional sums as necessary to be appropriated for the Exchange.

Only one Exchange could operate in a state. The Commissioner would be required to approve a state-based Exchange that met specified criteria. (A group of states could also operate a multi-state Exchange.) State-based Exchanges would be funded through a federal matching grant to states. If a state was operating an "Exchange" prior to January 1, 2010, and sought to operate a state-based Exchange under this section, the Commissioner would presume the Exchange meets the required standards. The Commissioner would be required to establish a process to work with such a state, but could determine, after working with the state, that the state does not comply with such standards.

Beginning in 2013, excluding grandfathered plans, new nongroup coverage could only be obtained through the Exchange. The public health insurance option and the income-based premium and cost-sharing credits for certain individuals (described below) would be available only through the Exchange. As described below, certain small employers could offer and contribute toward coverage through the Exchange.

CBO estimated that by 2019, 30 million people would obtain Exchange coverage (9 million of whom would get it through a qualified employer). Of those, about 6 million are projected to enroll in the public health insurance option.<sup>32</sup>

## Individual and Employer Eligibility for Exchange Plans

Beginning in 2013, individuals would be eligible for Exchange coverage unless they were enrolled in any of the following:

- a group plan through a full-time employee (including a self-employed person with at least one employee) for which the employer makes an adequate contribution (described in the section on employer mandates),
- Medicare, and
- Medicaid.

Individuals would generally lose eligibility for Exchange coverage once they become *eligible* for Medicare Part A, Medicaid, and other circumstances as the Commissioner provides.<sup>33</sup> Besides

<sup>31</sup> Sections 411(3) and 413(a)(1) of H.R. 3962.

<sup>32</sup> Congressional Budget Office, Letter to Rep. John D. Dingell, Analysis of the Affordable Health Care for America Act, [http://www.cbo.gov/ftpdocs/107xx/doc10706/hr3962Dingell\\_with\\_mgr\\_amendment.pdf](http://www.cbo.gov/ftpdocs/107xx/doc10706/hr3962Dingell_with_mgr_amendment.pdf).

<sup>33</sup> Sec. 302(d)(3)(B) of H.R. 3962.

those cases, once individuals enroll in an Exchange plan, they would continue to be eligible until they are no longer enrolled.

An open-enrollment period would be offered annually, sometime during September to November, lasting at least 30 days. There would also be special enrollment periods for certain circumstances (e.g., loss of acceptable coverage, change in marital or dependent status).

Exchange-eligible employers could meet the requirements of the employer mandate by offering and contributing adequately toward employees' enrollment through the Exchange. Those employees would be able to choose any of the available Exchange plans. Once employers are Exchange eligible and enroll their employees through the Exchange, they would continue to be Exchange eligible, unless they decided to then offer their own QHBPs.

In 2013, employers with 25 or fewer employees would be Exchange-eligible. In 2014, employers with 50 or fewer employees would be Exchange-eligible. In 2015, employers with 100 or fewer employees would be Exchange-eligible. Beginning in 2015, the Commissioner could permit larger employers to participate in the Exchange; these additional employers could be phased in or made eligible based on the number of full-time employees or other considerations the Commissioner deems appropriate.

### **Benefit Packages in the Exchange**

Exchange plans would have to meet not only the new federal requirements of all private health insurance plans (i.e., be QHBPs), but would also have their cost-sharing options somewhat standardized into the following four cost-sharing/benefit tiers:

- An Exchange-participating “entity” (insurer) must offer only one Basic plan in the service area. The Basic plan would be equivalent to the minimum requirements of the essential benefits package (e.g., actuarial value of approximately 70%).
- If the entity offers a Basic plan in a service area, it may offer one Enhanced plan in the service area, which would have a lower level of cost-sharing for benefits in the essential benefits package (i.e., actuarial value of approximately 85%).
- If the entity offers an Enhanced plan in a service area, it may offer one Premium plan in the service area, which would have a lower level of cost-sharing for benefits in the essential benefits package (i.e., actuarial value of approximately 95%).
- If the entity offers a Premium plan in a service area, it may offer one or more Premium-Plus plans in the service area. A Premium-Plus plan is a Premium plan that also provides additional benefits, such as adult oral health and vision care.

Plans would use the cost-sharing levels specified by the Secretary for each benefit category in the essential benefits package, for each cost-sharing tier (Basic, Enhanced and Premium)—although plans would be permitted to vary the cost-sharing from the specified levels by up to 10%. If a state requires health insurers to offer benefits beyond the essential benefits package, such requirements would continue to apply to Exchange plans, but only if the state has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any resulting net increase in premium credits.

## Public Health Insurance Option

Under H.R. 3962, the Secretary of HHS would establish a public health insurance option through the Exchange. Any individual eligible to purchase insurance through the Exchange would be eligible to enroll in the public option, and may also be eligible for income-based premium and cost-sharing credits. The public option would have to meet the requirements that apply to all Exchange-participating plans, including those related to benefits, provider networks, consumer protections, and cost-sharing. The public option would be required to offer Basic, Enhanced, and Premium plans, and could offer Premium-Plus plans.

The Secretary would be required to establish geographically adjusted premiums that comply with the premium rules established by the Commissioner and at a level sufficient to cover expected costs (including claims, administration, and a contingency margin). Limited start-up funding would be available, but would be repaid within 10 years. The public option would be prohibited from receiving federal funds if it became insolvent.

Under H.R. 3962, the Secretary would be required to negotiate payment rates for health care providers, and items and services (including prescription drugs), subject to limits. Specifically, the payment rates in aggregate would not be allowed to be lower than rates under Medicare, and not higher than average rates paid by other qualified health benefit offering entities.

Medicare-participating providers would also be providers for the public option, unless they chose to opt out in a process established by the Secretary through a rule making process that included a public notice and comment period. Physicians would be able to participate in the public option as preferred or non-preferred providers; preferred physicians would be prohibited from balance-billing (that is, billing for amounts above the established rates), while non-preferred physicians could balance-bill up to 115% of a reduced payment rate. Non-physician providers would be prohibited from balance-billing. The Secretary would have the authority to use innovative payment methods (including bundling of services, performance-based payments, and utilization-based payments) under the public option. The Secretary would be required to implement payment and delivery system reforms under the public option that had been determined successful under other parts of this Act.

The Secretary would be allowed to enter into no-risk contracts for the administration of the public option, in the same way the Secretary enters into contracts for the administration of the Medicare program. The administrative functions would include, subject to restrictions, determination of payment amounts, making payments, beneficiary education and assistance, provider consultative services, communication with providers, and provider education and technical assistance. The Secretary would be required to enter into a memorandum of understanding with the Secretary of Veterans Affairs for the collection of costs associated with nonservice-connected care provided in VA facilities to public health insurance enrollees.<sup>34</sup>

Enrollment in the public option would be voluntary. In general, any employee, including a Member of Congress, could forgo employment-based health insurance and choose instead to enroll in health insurance through any Exchange plan, including both public and private plans. As discussed in the section on employer mandates, individuals, including Members of Congress, who reject employer sponsored insurance and instead choose an Exchange plan would generally be responsible for 100% of the premium in the Exchange.

<sup>34</sup> Currently the Department of Veterans Affairs (VA), under certain circumstances, bills private health insurance companies if their enrollees receive nonservice-related care in a VA facility. For more information, CRS Report R40737, *Veterans Medical Care: FY2010 Appropriations*, by Sidath Viranga Panangala.

## **Consumer Operated and Oriented Plan (CO-OP) Program**

The bill would also require the Commissioner to establish, in consultation with the Secretary of the Treasury, a Consumer Operated and Oriented Plan (CO-OP) program under which the Commissioner would make grants and loans for the establishment of not-for-profit, member-run health insurance cooperatives in the Exchange. The bill would authorize the appropriation of \$5 billion for the period of fiscal years 2010 through 2014 for the program. Loans and grants would be used for start up costs and for solvency requirements. Grants and loans would only be made if the following conditions were met:

- The cooperative is a not-for-profit, member organization under the law of each state in which it offers, or intends to offer, insurance coverage made up entirely of beneficiaries of the insurance coverage offered by such cooperative.
- The cooperative did not offer insurance on or before July 16, 2009, and the cooperative is not an affiliate or successor to an insurance company offering insurance on or before such date.
- The governing documents of the cooperative incorporate ethical and conflict of interest standards designed to protect against insurance industry involvement and interference in the governance of the cooperative.
- The cooperative is not sponsored by a state government.
- Substantially all of the activities of the cooperative consist of the issuance of QHBPs through the Health Insurance Exchange or a state-based health insurance exchange.
- The cooperative is licensed to offer insurance in each state in which it offers insurance.
- The governance of the cooperative must be subject to a majority vote of its members.
- As provided in guidance issued by the Secretary of Health and Human Services, the cooperative operates with a strong consumer focus, including timeliness, responsiveness, and accountability to members.
- Any profits made by the cooperative are used to lower premiums, improve benefits, or to otherwise improve the quality of health care delivered to members.

In making grants and loans, the Commissioner would give priority to cooperatives that operate on a statewide basis, use an integrated delivery system, or have a significant level of financial support from nongovernmental sources. If a cooperative were to violate the terms of the CO-OP program and failed to correct the violation within a reasonable period of time, as determined by the Commissioner, the cooperative would be required to repay the total amount of any loan or grant received plus interest. Cooperatives would be permitted to integrate across state lines.

## **Premium and Cost-Sharing Credits**

Some individuals would be eligible for premium credits (i.e., subsidies) toward their required purchase of health insurance, based on income. However, even when individuals have health insurance, they may be unable to afford the cost-sharing (deductible and copayments) required to obtain health care. Thus subsidies may also be necessary to lower the cost-sharing. Under H.R.

3962, those eligible for premium credits would also be eligible for cost-sharing credits (i.e., subsidies).

In 2103 and 2014, these subsidies would only be available for Basic plans sold through the Exchange, including both the private plans and public option. Beginning in 2015, individuals eligible for credits could obtain an Enhanced or Premium plan, but would be responsible for any additional premiums and would not be eligible for cost-sharing credits.<sup>35</sup>

### Individual Eligibility for Premium Credits and Cost-Sharing Credits

Under H.R. 3962, Exchange-eligible individuals could receive a credit in the Exchange if they

- are lawfully present in a state in the United States, with some exclusions;<sup>36</sup>
- are not enrolled under an Exchange plan as an employee or their dependent (through an employer who purchases coverage for its employees through the Exchange and satisfies the minimum employer contribution amounts);
- have modified adjusted gross income<sup>37</sup> (MAGI) of less than 400% of the federal poverty level (FPL);<sup>38</sup>
- are not *eligible* for Medicaid;
- are not enrolled in an employer's QHBP, a grandfathered plan (group or nongroup), Medicare, Medicaid, military or veterans' coverage, or other coverage recognized by the Commissioner; and
- are not a full-time employee in a firm where the employer *offers* health insurance and makes the required contribution toward that coverage.<sup>39</sup>

### Calculation of Premium Credit

The premium credit is based on what is considered an "affordable premium amount" for individuals to pay. The affordable premium amount is a percentage of individuals' income (MAGI) relative to the poverty level, as specified in **Table 2** for 2013. For more details on the premium credits than provided here, see CRS Report R40878, *Health Insurance Premium Credits Under H.R. 3962*.

<sup>35</sup> Sec. 341(c)(1) and (2) of H.R. 3962.

<sup>36</sup> Nonimmigrants are those who are in the United States for a specified period of time and a specific purpose. The exceptions include aliens with nonimmigrant status because they are trafficking victims, crime victims, fiancées of U.S. citizens, or have had applications for legal permanent residence (LPR) status pending for three years. It is expected that almost all aliens in these nonimmigrant categories will become LPRs (i.e., immigrants) and remain in the United States permanently. A more detailed description of the eligibility criteria for credits vis-à-vis citizenship and lawful residence, as well as the processes to verify individuals' status, is available in CRS Report R40889, *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation*, by Ruth Ellen Wasem.

<sup>37</sup> For this purpose, MAGI is defined as adjusted gross income (AGI) without the exclusions for U.S. citizens or residents living abroad, plus tax-exempt interest.

<sup>38</sup> The federal poverty level used for public program eligibility varies by family size and by whether the individual resides in the 48 contiguous states and the District of Columbia versus Alaska and Hawaii. For a two-person family in the 48 contiguous states and the District of Columbia, the federal poverty level (i.e., 100% of poverty) was \$14,570. See 74 *Federal Register* 4200, January 23, 2009, <http://aspe.hhs.gov/poverty/09fedreg.pdf>.

<sup>39</sup> Exceptions would be made for certain individuals (e.g., divorced or separated individuals). Exceptions would also be made, beginning in 2014, for full-time employees of any income whose premium costs under a group health plan exceed 12% of current modified adjusted gross income.



Beginning in 2014, the Commissioner would adjust the percentages in the table generally so that the percentage of premiums paid by the government versus enrollees in each income tier remains the same as in 2013.

The premium against which credits would be calculated—the “reference premium”—would be the three Basic plans with the lowest premiums in the area (although the Commissioner could exclude plans with extremely limited enrollment). The “affordability premium credit” would be the lesser of (1) how much the enrollee’s premium exceeds the affordable premium amount, or (2) how much the reference premium exceeds the affordable premium amount.

**Table 2. Determination of Affordable Premium Amount, by Percentage of Income Relative to Poverty Level**

Federal poverty level (FPL)	Out-of-pocket premium limit (as a percent of income)
133% or less	1.5%
150%	3.0%
200%	5.5%
250%	8.0%
300%	10.0%
350%	11.0%
400%	12.0%

The Commissioner would establish premium percentage limits so that for individuals whose family income is between the income tiers specified in the table above, the percentage limits would increase on a linear sliding scale. The affordable premium credit amount would be calculated on a monthly basis.

### Calculation of Cost-Sharing Credit

In addition, those who qualified for premium credits in 2013 would also be eligible for assistance in paying any required cost-sharing for their health services. The Commissioner would specify reductions in cost-sharing amounts and the annual limitation (out-of-pocket maximum) on cost-sharing under a Basic plan so that the average percentage of covered benefits paid by the plan (as estimated by the Commissioner) is equal to the percentages (actuarial values) in the **Table 3** for each income tier.

In addition, **Table 3** also shows the annual out-of-pocket maximum individuals would have to pay toward cost-sharing (e.g., deductibles, copayments—excluding premiums), with the Commissioner given the flexibility to alter the amounts in order to meet the actuarial values. The out-of-pocket limits in the table would be doubled for family coverage. The out-of-pocket limits in each tier would be increased in future years based on the percentage growth in premiums for Basic plans.

**Table 3. Cost-Sharing Credits: Average Percentage of Covered Benefits Paid by Plan, and Out-of-Pocket Maximum, by Income Tier**

Federal poverty level (FPL)	Actuarial value (percentage)	Out-of-pocket limit (2013)
150% or less	97%	\$500
200%	93%	\$1,000
250%	85%	\$2,000
300%	78%	\$4,000
350%	72%	\$4,500
400%	70%	\$5,000

The Commissioner would pay insurers additional amounts to cover the reduced cost-sharing provided to credit-eligible individuals.

## Selected Revenue Provisions Relating to Private Health Insurance

The House bill includes a number of provisions to raise revenues to pay for expanded health insurance coverage. Some of these provisions are directly related to current health insurance coverage. These provisions limit employer deductions for certain health insurance plans and modify tax-advantaged accounts currently used for health care spending and coverage. They are discussed in greater detail in this section. **Table 4** identifies these provisions, their effective date, and recent estimates by the Joint Committee on Taxation (JCT) of the how much revenue each raise over a 10-year period. Those provisions not directly relating to health insurance will not be discussed in this section.<sup>40</sup>

**Table 4. Selected Revenue Provisions of H.R. 3962**

As Reported on October 29, 2009

	Effective Date <sup>a</sup>	Increase in Revenues (FY2010-FY2019)
<b>Limitations On Employer Deductions</b>		
Eliminate deductions for retiree expenses allocable to Medicare Part D subsidy	Dec. 31, 2012	\$2.2 billion <sup>b</sup>
<b>Modifications to Tax-Advantaged Accounts Used for Health Care</b>		
Limit Health Flexible Spending Accounts (FSAs) to \$2,500	Dec. 31, 2012	\$13.3 billion

<sup>40</sup> For more information on these other revenue provisions, see Congressional Budget Office, letter to Rep. Charles B. Rangel, "Preliminary Analysis of the Affordable Health Care for America Act," <http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf>. The key revenue provision that will raise the largest revenues is a 5.4% surtax on adjusted gross income in excess of \$500,000 for single filers and \$1 million for joint returns. The threshold will not be indexed for inflation. This provision will be implemented in tax years beginning after December 2010. According to the Joint Committee on Taxation, it is expected to raise \$460 billion over a ten year period.



	Effective Date <sup>a</sup>	Increase in Revenues (FY2010-FY2019)
Raise penalty for non-qualified HSA withdrawals from 10% to 20%	Dec. 31, 2010	\$1.3 billion
Change the definition of medical expenses for FSAs and Health Savings Accounts (HSAs)	Dec. 31, 2010	\$5.0 billion <sup>c</sup>
<b>Total Revenues Relating To Private Health Insurance</b>	—	<b>\$21.8 billion</b>

**Source:** Joint Committee on Taxation, *Estimated Revenue Effects of Revenue Provisions Contained in H.R. 3962, The Affordable Health Care For America Act, As Amended*, November 6, 2009, JCX-53-09.

- a. Effective date for tax years beginning after the date specified below.
- b. Estimate includes interaction with other proposals.
- c. Estimate includes interaction effect with FSA cap.

## Eliminate Employer Deduction for Retiree Coverage Eligible for Federal Subsidy

Under current law, employers providing prescription drug coverage to retirees that meet federal standards are eligible for subsidy payments from the federal government. These qualified retiree prescription drug plan subsidies are excludible from the employer's gross income for the purposes of regular income tax and alternative minimum tax calculations. The employer is also allowed to claim a business deduction for retiree prescription drug expenses even though they also receive the federal subsidy to cover a portion of those expenses. H.R. 3962 would require employers to coordinate the subsidy and the deduction for retiree prescription drug coverage. In this provision, the amount allowable as a deduction for retiree prescription drug coverage would be reduced by the amount of the federal subsidy received. According to the JCT, this provision would raise \$2.2 billion over a 10-year period (see **Table 4**).

## Modifications to Tax-Advantaged Accounts Used to Pay for Health Care Expenses

There are a number of tax-advantaged accounts and tax deductions for health care spending and coverage that will be affected by the revenue provisions in H.R. 3962. Under current law, flexible spending accounts (FSAs), health spending accounts (HSAs), health reimbursement accounts (HRAs) and Medical Saving Accounts (MSAs) all allow workers under varying circumstances to exclude a certain portion of qualified medical expenses from income taxes.<sup>41</sup>

Health FSAs are employer-established benefit plans that reimburse employees on a pre-tax basis for specified health care expenses (e.g. deductibles, co-payments, and non-covered expenses).<sup>42</sup> About one-third of workers in 2007 had access to an FSA.<sup>43</sup> FSAs are generally funded through the employee's election amount for salary reduction. Under current law, it is at the discretion of

<sup>41</sup> See CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by Janemarie Mulvey.

<sup>42</sup> See CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Janemarie Mulvey.

<sup>43</sup> Bureau of Labor Statistics, *Table 24. Pretax benefits: Access, private industry workers*, National Compensation Survey, March 2007.

each employer to set limits on FSA contributions. In 2008, the average FSA contribution was \$1,350.<sup>44</sup> H.R. 3962 would limit the amount of annual FSA contributions to \$2,500 per person beginning in 2013. This threshold would be indexed to inflation in subsequent years. According to the JCT, this provision would raise \$13.3 billion over 10 years (see **Table 4**).

HSAs are also tax-advantaged accounts that allow individuals to fund unreimbursed medical expenses on a pre-tax basis.<sup>45</sup> Eligible individuals can establish and fund accounts when they have a qualifying high deductible health plan and no other health plan (with some exceptions). Unlike FSAs, HSAs may be rolled over and the funds accumulated over time. Distributions from an HSA that are used for qualified medical expenses are not included in taxable income. Distributions taken by individuals from an HSA that are not used for qualified medical expenses are taxable as ordinary income and, for those under age 65, are subject to an additional 10% penalty tax. H.R. 3962 increases the penalty on non-qualified distributions to 20% of the disbursed amount. According to the JCT, this provision would raise \$1.3 billion over 10 years (see **Table 4**).

In addition to the specific provisions in H.R. 3962 that directly modify these tax-advantaged plans, the House proposal would also modify the definition of qualified medical expenses, which affects all of the tax-advantaged accounts. Under current law qualified medical expenses for FSAs, HSAs, and HRAs can include over-the-counter medications. H.R. 3962 would not allow over-the-counter prescriptions to be covered by these tax-advantaged account unless they are prescribed by a physician. According to the JCT, this provision would increase revenues by \$5.0 billion over 10 years (see **Table 4**).

## Other Provisions

### Abortion

Under H.R. 3962, state laws regarding the prohibition or requirement of coverage or funding for abortions, and state laws involving abortion-related procedural requirements, would not be preempted. Federal conscience protection and abortion-related antidiscrimination laws, as well as Title VII of the Civil Rights Act of 1964, would also not be affected by the measure.

H.R. 3962 would prohibit a federal agency or program, or state or local government that receives federal financial assistance under the measure, from

- subjecting any individual or institutional health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions, or
- requiring any health plan created or regulated under the bill to subject any individual or institutional health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

H.R. 3962 would restrict the recommendation and adoption of standards related to abortion as part of the essential benefits package. A QHBP would not be prohibited, however, from providing coverage for either elective abortions or abortions for which federal funds appropriated for HHS are permitted. Currently, such funds may be used to pay for abortions if a pregnancy is the result

<sup>44</sup> Mercer Human Resources Consulting, *National Survey of Employer-Sponsored Health Plans 2008*.

<sup>45</sup> See CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2009*, by Janemarie Mulvey.

of an act of rape or incest, or where a woman suffers from a physical disorder, physical injury, or physical illness that would place the woman in danger of death unless an abortion is performed.<sup>46</sup>

The Stupak Amendment, adopted by a vote of 240-194, added additional restrictions on the use of funds authorized or appropriated by H.R. 3962.<sup>47</sup> Under the Stupak Amendment, such funds could not be used to pay for an abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except where a woman suffers from a physical disorder, physical injury, or physical illness that would place the woman in danger of death unless an abortion is performed, or if a pregnancy is the result of an act of rape or incest.

The Stupak Amendment would permit nonfederal entities, including individuals and state or local governments, to purchase separate supplemental coverage for elective abortions or a plan that includes coverage of such abortions, but would require that the supplemental coverage or the plan be paid for entirely with funds not authorized or appropriated by H.R. 3962. In addition, the supplemental coverage or plan could not be purchased with either premium payments toward which an affordability credit is applied or nonfederal funds that are required to receive an affordability credit.

The Stupak Amendment would not restrict nonfederal QHBP offering entities from offering separate supplemental coverage for elective abortions or a plan that covers such abortions. However, premiums for that coverage or plan would have to be paid for entirely with funds not authorized or appropriated by H.R. 3962, and the administrative costs and all services offered through the supplemental coverage or plan would have to be paid for using only premiums collected for such coverage or plan. In addition, a nonfederal QHBP offering entity that offers an Exchange-participating health benefits plan that includes coverage for elective abortions would have to offer an identical plan that did not cover such abortions.

Finally, Exchange plans would be prohibited from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

## Medical Malpractice

H.R. 3962 would permit a state to receive an incentive payment if it enacted and implemented an alternative medical liability law that complied with the bill. An alternative medical liability law would be in compliance if the Secretary is satisfied that (1) the state enacted the law after the date of enactment of the bill and is implementing the law, (2) the law is “effective,” and (3) the law met certain requirements. To determine the effectiveness of a law, the Secretary would consider whether it made the medical liability system more reliable through the prevention of or prompt and fair resolution of disputes, it encouraged the disclosure of health care errors, and it maintained access to affordable liability insurance. The state law would be required to provide for either, or both, an “early offer” system, a “certificate of merit” program, and the law must not limit attorneys’ fees or impose caps on damages.

Generally, an early offer system would permit a defendant to offer to a claimant within 180 days after a claim is filed, periodic payment of the claimant’s net economic losses plus reasonable legal fees.<sup>48</sup> Economic losses under an early offer system would cover medical expenses,

<sup>46</sup> For additional information on the public funding of abortion, see CRS Report RL33467, *Abortion: Legislative Response*, by Jon O. Shimabukuro.

<sup>47</sup> See H.Amdt. 509, 111<sup>th</sup> Cong. (2009).

<sup>48</sup> It appears that no state currently has an early offer system as a part of its medical malpractice laws. See generally

including rehabilitation, plus lost wages, to the extent that all such costs are not already covered by insurance or other third party sources. If an early offer is not made, the injured party can proceed with a tort claim for both economic and noneconomic damages. However, if an early offer is made and the claimant declines the offer and proceeds with litigation, both the standard of misconduct and standard of proof are raised. A certificate of merit program requires claimants, when a medical malpractice suit is first filed, to include testimony from a qualified medical expert that establishes that there is merit to the claim.<sup>49</sup>

A state that received an incentive payment would have to use it to improve health care in the state.

The bill would authorize appropriation of such sums as may be necessary for the incentive payments, but would not actually provide funds for such payments.

The bill would clarify that nothing in the Act or amendments to the Act would modify or impair state law governing legal standards or procedures used in medical malpractice cases.

### **End-of-Life Planning**

QHBP would be required to provide for the dissemination of information related to end-of-life planning to individuals who seek enrollment in Exchange-participating plans. QHBPs would also be required to present individuals with the option to establish advance directives and physician's orders for life sustaining treatment, according to state laws, as well as present information related to other planning tools. However, the QHBP would be prohibited from promoting suicide, assisted suicide, or the active hastening of death.

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Joni Hersh, Jeffery O'Connell, and W. Kip Viscusi, "An Empirical Assessment of Early Offer Reform for Medical Malpractice," 36 J. Legal Stud. S231 (2007), Jeffrey O'Connell, Jeremy Kidd, and Evan Stephenson, "Early Offers: An Approach to Medical Malpractice Reform," *Contingencies* 42 (Sep/ Oct. 2006).

<sup>49</sup> Approximately 25 states have implemented a certificate or affidavit of merit requirement.

## Appendix. Timeline of Implementation Dates Under Division A of H.R. 3962 Prior to Full Implementation on January 1, 2013

Implementation Date	Section in H.R. 3962	Provision
"hereby established"	110	A prohibition on postretirement reductions in retiree health benefits.
"hereby established"	113	Would allow individuals to keep their COBRA coverage until the Exchange is up and running.
"hereby established"	114	The Secretary would enhance existing grant program incentives for states to move forward with a variety of health reform initiatives prior to 2013.
"hereby established"	262	Anti-trust law shall apply to health insurance except for the sharing and collection of data necessary for underwriting and actuarial analysis.
1/1/2010	101	The Secretary would establish a temporary national high-risk pool program to provide health benefits to eligible individuals during the period beginning on January 1, 2010 and ending when the Health Insurance Exchange is established.
1/1/2010	102	Each health insurance issuer that offers health insurance coverage in the small or large group market would provide a rebate if the coverage has a medical loss ratio below a level specified by the Secretary (but not less than 85%). The provision sunsets once plans are offered via the Exchange. This provision would also apply to the individual market unless the Secretary determines that the application of this policy may destabilize the existing individual market.
1/1/2010	104	Health insurance issuers would have to submit a justification for any premium increases prior to implementation of the increase to the Secretary and the States. State Insurance Commissioners would provide data to the Health Choices Commissioner on premium increases and trends. From 2010-2014 the Secretary would provide grants to the states for premium monitoring activities. The Secretary would also make these premium data publicly available.
1/1/2010	105	Would allow those through age 26 not otherwise covered to remain on their parents' group on individual plans at their parents' discretion.
1/1/2010	106, 107	In both the group and individual markets, (prior to the complete prohibition in 2013), the bill would reduce the window that plans can look back for pre-existing conditions from 6 months to 30 days and shorten the period that plans may exclude coverage of certain benefits. The bill would prohibit acts of domestic violence from being treated as a pre-existing condition.
1/1/2010	108	For both the group and individual markets, plans would have to cover benefits for a dependent child's congenital or developmental deformity or disorder.
1/1/2010	109	For both the group and individual markets, the bill would prohibit aggregate dollar lifetime limits on benefits.
Not later than 60 days after enactment	223	Appointments would be made to the Health Benefits Advisory Committee. The Committee would make recommendations on covered benefits and essential, enhanced, and premium plans.

Implementation Date	Section in H.R. 3962	Provision
Not later than 90 days after enactment	103	The Secretary would issue guidance implementing the prohibition on rescission in the group and individual markets.
90 days after enactment	111	The Secretary would establish a temporary reinsurance program to assist participating employment-based plans with the cost of providing health benefits to retirees and to eligible spouses, surviving spouses and dependents of such retirees.
Not later than 6 months after enactment	310	The bill would require that the Health Choices Commissioner to establish a Consumer Operated and Oriented Plan (CO-OP) program under which the Commissioner would make grants and loans for the establishment of not-for-profit, member-run health insurance cooperatives. These co-operatives would provide insurance through the Health Insurance Exchange or a State-based Health Insurance Exchange.
7/1/2010	112	The Secretaries of HHS and Labor would jointly award wellness program grants to small employers in an amount equal to 50% of the costs paid or incurred in connection with a qualified wellness program during the plan year.
Not later than 1 year after enactment	222	The Secretary of HHS would submit to Congress a report containing the results of a study determining the need and cost of providing oral health care to adults as part of the essential benefits package.
Not later than 1 year after enactment	223	Recommendations of the Health Benefits Advisory Committee on coverage benefits and plan types would be made to the HHS Secretary.
Not later than 18 months after enactment	213	The Health Choices Commissioner, in coordination with the Secretaries of HHS and Labor would conduct a study of the large-group-insured and self-insured employer health care market structure and participants. The study would examine the extent to which rating rules are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure.
Not later than 18 months after the enactment	224	The Secretary would, through the rulemaking process adopt an initial set of benefit standards.
Not later than 18 months before the first day of the public option	323	The Secretary would promulgate rules regarding the negotiated payments for the public health insurance option for health care providers and items and services, including prescription drugs.
Not later than 2 years after enactment	115	The Secretary would adopt and periodically update standards to simplify health insurance administrative and financial transactions.

No later than 1/1/2012	415	The Secretary of Labor would conduct a study to examine the effect of the employer responsibility requirements on employment-based health plan sponsorship, generally and within specific industries, and the effect of such requirements and thresholds on employers, employment-based health plans, and employees in each industry.
No later than 1/1/2012	416	The Secretaries of Labor, Treasury, and HHS, and the Commissioner, would conduct a study to examine the impact of the employer responsibility requirements and make a recommendation to Congress about whether an employer hardship exemption would be appropriate. They would examine cases where the employer responsibility requirements may pose a particular hardship, and specifically look at employers by industry, profit margin, length of time in business, and size.

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